(4) (5)

Nos. 97-1947 and 97-2079

Supreme Court, U.S.
FILED
SEP 25 1998
OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

BEVERLY COMMUNITY HOSPITAL ASSOCIATION DBA BEVERLY HOSPITAL, ET AL.,

Petitioners

v.

S. KIMBERLY BELSHE, Director of the California Department of Health Services, ET AL.,

Respondents

CALIFORNIA AMBULANCE ASS'N and CALIFORNIA MEDICAL ASS'N, ET AL.,

Petitioners

v.

S. KIMBERLY BELSHE, Director of the California Department of Health Services, ET AL.,

Respondents

On Petitions for Writ of Certiorari To The United States Court of Appeals For The Ninth Circuit

JOINT REPLY TO BRIEFS IN OPPOSITION

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INTRODUCTION

As the petitions establish, review is warranted because these cases present an important issue of statutory interpretation that has split six of the circuits, *i.e.*, the appropriate rate of reimbursement for providers of medical services to qualified Medicare beneficiaries ("QMBs") under the Medicare and Medicaid Acts, an issue of enormous financial consequences because it involves potential recoupment of amounts approaching $400 million in fees previously paid by the Medi-Cal program for medical services already rendered. Equally important, review is also necessary to resolve the jurisprudential question that directly caused the split, *i.e.*, given the courts' Constitutional duty to ascertain the meaning and intent of legislation, what deference is owed to a statute passed by later Congress which purports to clarify the meaning of a statute enacted by an earlier Congress, especially when Congress directs retroactivity only as to litigants.

Petitioners contend that because the two circuits faced with the deference issue became so entangled in deciding how much deference should be given, they failed to recognize the necessity of first ascertaining the intent of the Congress that enacted the original law, a task that lies solely within the purview and jurisdiction of the courts, not Congress. *Pierce v. Underwood*, 487 U.S. 552, 566 (1988). Guided by doctrines those courts interpreted to require controlling deference to the 1997 Congress' clarification of the 1986 Medicare legislation, neither the Ninth nor the Seventh Circuits engaged in any meaningful examination of the 1986 QMB legislation at issue here, including 42 U.S.C. §1396a(n) – the section that the 1997 Congress purported to clarify.

As if to underscore the Ninth and Seventh Circuits' failures to address the meaning and intent of the 1986 legislation, respondents made their discussion of these statutes a cornerstone of their opposition to the petitions in this case. However, in their effort to convince this Court that the "clarifying statute", §4714 of the Balanced Budget Act ("BBA") of 1997, correctly reflects the 1986 Congress' original intent, respondents present an inaccurate and misleading exposition of the Congressional intent be-

hind the QMB legislation and the administrative construction of the earlier "dual eligible" and QMB programs. Since these inaccuracies may directly impact this Court's determination whether further review is appropriate, petitioners address them here.

DISCUSSION

A. The Secretary Materially Misstates the Intent of the 1986 Legislation

The Secretary states, without citing any authority, that the purpose of the QMB legislation was "to relieve the States from the financial obligation that they would have to shoulder under their Medicaid plans if QMBs were not able to participate in the Medicare Part B program." Brief of Federal Respondent ("Brf. F.R."), p. 14. As the four circuits that did address the intent and purpose of the 1986 QMB legislation made clear, Congress' intent was to protect beneficiaries, not the states.

To begin with, in 1986, when Congress enacted the original QMB statutes, including the later-clarified §1396a(n), the states had no obligation under Medicaid to shoulder any financial obligations for QMBs if the latter were unable to participate in the Medicare Part B program because, by definition, QMBs were *not* eligible for Medicaid. Indeed, as the House Energy and Commerce Committee's Report reveals, the "devastating financial burden" faced by millions of the elderly poor was the crux of the problem Congress sought to address:

> that 20 percent of our senior citizens – 5 million people – *are without Medicaid* or private insurance to supplement their Medicare benefits. These beneficiaries, relying on Medicare alone to finance needed health services, are among the sickest and poorest of our senior and disabled citizens. They face substantial out-of-pocket costs for needed care and can incur devastating financial burdens when illness strikes.

H.R. Rep. No. 99-727, 99th Cong., 2d Sess., 102-03 (1986), *reprinted in* 1986 U.S.C.C.A.N. 3607, 3692-93 (emphasis added).

To aid and assist this segment of the elderly poor, the House

Committee drafted two sections of a bill that provided two options for healthcare coverage. The first, §4602, identical to its counterpart in the Senate, which later became §9402 of Pub. L. 99-509, allowed states to expand eligibility for the full range of Medicaid benefits for the elderly and disabled with incomes up to the poverty line. The second option, which became §9403 of Pub. L. 99-509 and contained the QMB provisions at issue here, offered states the more limited option of paying only the Medicare Part B premium and the other Part B cost-sharing requirements for Medicare beneficiaries who met a state's threshold requirements and fell below the Federal poverty line. *Id.*, at 105-6, *reprinted in* 1986 U.S.C.A.N.N. at 3695-96..

The legislative history demonstrates quite clearly that the purpose of the buy-in provisions was not, as the Secretary contends, "to relieve the States" from non-existent Medicaid financial obligations to QMBs unable to pay for Part B benefits. To the contrary, Congress was trying to induce states to provide limited Medicare gap-filling benefits for this class of the elderly poor.

The Secretary also erroneously claims that her "construction recognizes that, if the States did not buy QMBs into Medicare, the States would be required to pay for the medical care of at least those QMBs who are eligible for Medicaid, at whatever their Medicaid rates would allow." Brf. F.R., p. 14. This construction cannot be a proper interpretation of the 1986 QMB legislation because if the states elected not to participate in the QMB program, they were not otherwise required to pay for QMBs who were, at that time, by definition not Medicaid eligible. Pub. L. No. 99-509, §9403, 100 Stat. 1874, 2054-55 (codified as amended at §1396a(a)(10)(E)).

Having erroneously postulated that the states might have to incur Medicaid obligations for at least some of the QMBs who could not participate in the Medicare Part B program, the Secretary opines that it is "reasonable to conclude that the States should not have to pay for medical services at a rate that is higher than the rate at which their own Medicaid plans would otherwise have required payment." Brf. F.R., p.14. But the statutory language and the legislative history demonstrates that

Congress intended that for those qualified *Medicare* beneficiaries who would not be eligible under §9403 for full *Medicaid* benefits, *Medicare* cost-sharing would be exactly what the name implies, *i.e.*, a full sharing of *Medicare* costs and *Medicare* benefits for *Medicare* beneficiaries. *See Pennsylvania Medicaid Soc. v. Snider*, 29 F.3rd 886, 899 (3rd Cir. 1994) ("*Snider*"); *see* also H.R. Rep. No. 99-727, at 104, 106, *reprinted in* 1986 U.S.C.C.A.N. 3607, 3694, 3696.

Had either the Ninth or Seventh Circuits engaged in a true analysis of the meaning and intent of the 1986 legislation, as had the four other circuits that addressed this issue, they would have similarly determined that the 1997 BBA amendments, like the Secretary's position here, were at odds with the intent of the 1986 legislation and could not constitute a "clarification" to which any deference is owed. Instead, the Ninth Circuit merely observed that the courts had encountered "extraordinary difficulty in discovering the intent of the original Congress" and on that basis concluded that Congress' 1997 "clarification" of §1396a(n) was worthy of "real deference." *Beverly Community Hospital Ass'n v. Belshe*, 132 F.3d 1259, 1266 (9th Cir. 1997) ("*Beverly*"). However, "[c]omplexity alone is not enough to trigger *Chevron* [deference]." *Snider*, *supra*, 29 F.3d at 902. Petitioners have elsewhere shown that this deference was not warranted. The Seventh Circuit was properly, but not sufficiently, skeptical in evaluating the same purported "clarification":

> The location of the 1997 amendments in a statute labeled the "Balanced Budget Act" and concerned primarily with cutting the federal deficit hardly creates confidence that Congress was, court-like, interpreting the 1986 statute. It is far more realistic to regard the 1997 QMB provisions as designed to change the original statute in order to reduce the cost of Medicaid to the federal government. Nothing in the provisions themselves suggests a process of interpretation; they merely declare that the states are not required to reimburse QMB providers at the Medicare rate.

Paramount Health Services, Inc. v. Wright, 138 F.3rd 706, 710 (7th Cir. 1998)).

Nowhere in its opinion does the Ninth Circuit explain how it concluded that §4714's provisions are a "statement of what §1396a(n) had meant all along." *Beverly*, 132 F.3d at 1266. Indeed, nowhere does that court engage in an analysis of the meaning and intent of the 1986 QMB legislation so as to justify its assertion.

The Ninth Circuit's avoidance of any independent determination of the intent of the 1986 legislation through the deference it uncritically accorded the 1997 "clarification" only underscores the importance of this case. Supreme Court review is necessary to resolve the apparent conflict in this Court's decisions as to the judicial "deference" owed to subsequent congressional "clarifications" in light of the fundamental principle that the judiciary, not Congress, is entrusted under the Constitution with the *independent* duty to interpret the meaning and intent of federal legislation. *See City of Boerne v. Flores*, ___ U.S. ___, 138 L.Ed. 2d 624 (1997).

B. Post-Enactment Legislative History

Respondents attempt to bolster their erroneous view of the intent of the 1986 Legislation by an equally mistaken and selective review of its post-enactment history.

1. 1988. Respondents first rely on selected language contained in a Health Energy and Commerce Report accompanying the Medicare Catastrophic Coverage Act of 1988, which referred to the Committee's understanding of the "practice" of some states to limit their Medicare cost-sharing payments. H.R. Rep. No. 100-105(II), 100th Cong., 2d Sess., 61 (1988), *reprinted in* 1988 U.S.C.C.A.N. 857, 884. Respondents ignore, however, that the same House Report elsewhere states in discussions of its version of the bill: "States would be required to pay the Medicare premiums, deductibles and co-insurance for all Medicare enrollees with incomes at or below the federal poverty guideline and assets at or below twice the supplemental security income guidelines." *Id.*, at 36, 1988 U.S.C.C.A.N. 857, 859. Furthermore, nothing in the three other reports accompanying the 1988 legislation, including a House Ways and Means Committee re-

port, a Senate report, and a House Conference report, indicates that either the full House or the Senate agreed with the Energy and Commerce Committee's initial comments. Indeed, the House Ways and Means Committee noted that for QMBs, states would be *required* "to pay the Medicare premium, deductibles and co-insurance [amounts]." H.R. Rep. No. 100-105(I), 100th Cong., 2d Sess., 6 (1988), 253, *reprinted in* 1988 U.S.C.C.A.N. 803, 808. The final Conference agreement accompanying the legislation did not incorporate any discussion similar to that Respondents rely upon, but instead referenced and reaffirmed the language in the Ways and Means Report. H.R. Conf. Rep. No. 100-661, 100th Cong., 2d Sess., 253 (1988), *reprinted in* 1988 U.S.C.C.A.N. 923, 1031.

Most important, the legislation ultimately passed in 1988 did not modify the payment provisions enacted in 1986 relating to QMBs in 42 U.S.C. §§1396d(p) and 1396a(n); it merely deleted two phrases that had previously made the State's Medicaid program's participation in the QMB program optional. Pub. L. No. 100-360, §301(a)(1), 102 Stat. 683, 748. Accordingly, whatever the House Energy and Commerce Committee meant by its inconsistent report language did not materialize in the form of actual legislation in 1988. [1] *See Rehabilitation Ass'n. of Virginia v. Kozlowski*, 42 F.3d 1444, 1458 (4th Cir. 1994), *cert. den.* 516 U.S. 811 (1995) ("*Kozlowski*") ["the only way to change a law is to actually change a law, not to drop contrary language into committee reports addressing totally unrelated provisions"].

Because of all of this, which Respondents fail to disclose in their opposition, coupled with this Court's general warning regarding the troublesome nature of subsequent legislative history,[2] neither the Second Circuit in *New York City Health & Hosp.*

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[1] Because the report language purports to describe the "practice" of some states under the "dual-eligible" program which was repealed in 1988, it certainly has little value in interpreting §1396a(a)10)(E) or §1396d(p)(3) as to the scope of the states' obligations to make payments for Medicare cost-sharing. *Snider*, 29 F.3d at 898.

[2] *See Pierce v. Underwood*, 487 U.S. 552, 566 (1988); *Consumer Product Safety Comm'n v. GTE Sylvania, Inc.*, 447 U.S. 102, 116-20 (1980); *Oscar Mayer & Co. v. Evans*, 441 U.S. 750, 758 (1979).

Corp. v. Perales, 954 F.2d 854, 861 (2nd Cir.), *cert. den.* 506 U.S. 973 (1992) ("*Perales*"), nor the Third Circuit in *Snider*, 29 F.3d at 894, nor the Fourth Circuit in *Kozlowski*, 42 F.3d at 1457, were willing to accept the one inconsistent snippet of post-enactment legislative history contained in the 1988 House Energy and Commerce Committee Report as an indication that Congress intended to enact a wrenching change of its original intent in establishing the "dual eligible" and QMB programs as unambiguously set forth in their *contemporaneous* legislative history, which expressly and specifically stated that the states had to provide full payment for Medicare cost-sharing. *Kozlowski*, 42 F.3d at 1457. *See* S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* 1965 U.S.C.C.A.N. 1943, 2020; H.R. Rep. No. 99-727, at 106, *reprinted in* 1986 U.S.C.C.A.N. at 3696.

2. 1989. The Secretary notes that in 1989, Congress amended the QMB provisions by requiring physicians to accept assignment of claims from QMBs. Pub. L. No. 101-239, §6102(a), 103 Stat. 3805. Relying on an alleged State practice of limiting reimbursement of providers of "dual eligibles" to the Medicaid rate, the Secretary claims that the "specific purpose" of this new legislation was to prevent physicians from exceeding the Medicaid ceilings by billing QMBs for such additional amounts. Brf. F.R., p. 14. The Secretary is wrong.

First, the legislation she describes as "amended ... QMB provisions" is neither an amendment nor is it principally related to the QMB program. Section 1848 of the Social Security Act was added through §6102 of the Omnibus Budget Recovery Act of 1989 ("OBRA '89") as comprehensive physician payment reform under Part B of the Medicare program. Section 6102 created a relative value-based fee schedule for payment by Medicare to Medicare "participating" physicians, replacing the prior charge based system, and established a series of limits for charge reimbursement that applies to physicians not accepting assignments under Medicare that significantly circumscribes their ability to pursue payments from Medicare beneficiaries *above* the *Medicare coinsurance and deductible* amounts (commonly referred to as "balance billing"). H.R. Conf. Rep. No. 101-386, 101st Cong., 1st Sess., 738-63, *reprinted in* 1989 U.S.C.C.A.N.

at 3341-65.

As part of the limitation against "balance billing" by "nonparticipating" physicians, Congress prohibited billing on other than a Medicare assignment-related basis, in the case of QMBs and other dual eligibles. 42 U.S.C. §1395w-4(g)(3). Thus, just as with participating physicians, nonparticipating physicians providing services to QMBs are only entitled to payment of Medicare coinsurance and deductibles, in addition to Medicare's payment, and may not balance bill the patients for any difference between their charges and the Medicare fee schedule.

Second, the Conference Report that accompanied this provision states: "Further, assignment is mandated for all claims submitted for beneficiaries for whom *Medicaid is required to pay Medicare cost-sharing charges*." H.R. Conf. Rep. No. 101-386 at 761, *reprinted in* 1989 U.S.C.C.A.N. at 3364. This statement from the Conference Committee does not reflect any understanding of the practice of some state Medicaid programs of eliminating or reducing Medicare cost-sharing for "dual eligibles" that is even remotely similar to the earlier and gratuitous statements of the House Budget Committee in H.R. Rep. No. 101-247, 101st Cong., 1st Sess., 247, *reprinted in* 1989 U.S.C.C.A.N 1906, 2090, at least as that report is characterized by the Secretary. It also makes clear that QMBs are principally Medicare, not Medicaid beneficiaries, given that it is Medicare cost-sharing that must be paid.[3]

Consequently, in her brief, the Secretary has mischaracterized the nature and context of the 1989 legislation, and has ignored the relevant legislative history from the Conference Committee explaining the limited purpose of the 1989 amendments.

C. Lack of Any Longstanding Policy

The Secretary claims that §4714(a) confirms her longstand-

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[3] Additionally, the House Committee commentary, written more than 20 years after the enactment of §1396a(a)(15) (now repealed) dealing with "dual eligibles" did not purport to construe the statute; it only referred to the "practice" of some states and, therefore, carries little weight. *Perales*, 954 F.2d 854, 861; *Snider*, 29 F.3d 886, 900-01; *Kozlowski*, 42 F.3d 1444, 1458.

ing position before the enactment of the 1997 Act that a state could limit or eliminate Medicare cost-sharing by utilizing the state's Medicaid payment "caps." Two courts, however, have found the Secretary did not have a longstanding consistent position, but, in fact, had previously adopted a contrary position to the one assumed for purposes of the litigation, thereby eroding the deference normally to be afforded. *Perales*, 954 F.2d at 862; *Snider*, 29 F.3d at 902. As to Part B benefits, petitioners have demonstrated that the Secretary's present "litigation inspired" position of 9 years (1989-98), dating from the beginning of the QMB litigation, is both shorter than and directly contrary to her previous longer-standing position of 18 years (1971-89). Calif. Ambulance Ass'n, et al., Pet. for Cert., pp. 6-7. In regulations published in 1987 under 42 U.S.C. §1396a(a)(15) of the Act, the Secretary made it clear that the State's option to pay less than full cost-sharing was limited to a nominal amount "to be paid by the Medicaid recipient ... reasonably related to the recipient's income and resources." 42 C.F.R. §431.626(a)(5). These regulations remain in effect today.

With respect to Part A payments in California, one may describe the Secretary's position as firmly rooted in shifting sand. From the beginning of the Medicare and Medicaid programs, until it changed its policy as of May 1, 1994, California paid the full amount of cost-sharing payments for Part A services. In May of 1994, it adopted a new policy to pay *none* of the Medicare cost-sharing for Part A services, even when the State's Medi-Cal rate exceeded the amount paid by Medicare.[4] This is contrasted with the Secretary's currently-stated policy that "a State may limit its cost-sharing payments to the difference between the State's Medicaid rate and the amount that Medicare pays for a given service." Brf. F.R., p. 12. According to the

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[4] In regard to Part A, the Secretary misstates the facts when she asserts that "[p]etitioners challenged California's policy, reflected in state regulations and in a state plan approved by the Secretary, of limiting cost-sharing payments to the amount (if any) by which the California Medicaid rate exceeds what Medicare pays." Brf. F.R., p. 9. In fact, the policy challenged by petitioners in *Beverly* provided that California would not pay cost-sharing in any circumstances.

State's policy, it will not pay any of the cost-sharing. Nevertheless, the Secretary approved the State's Plan Amendment incorporating this policy in February 1996. Beverly Community Hospital Ass'n, Appellant's Brief, Exh. 1. Subsequently, when §4714 made it clear that a State must make cost-sharing payments up to its Medicaid rate, the Secretary changed her position and informed California that the policy to make zero payments in all cases was not acceptable. *Id.*, Pet. Reh., at 11 n. 11. The Secretary's change in attitude about the extent of the State's obligation shows clearly that she has not had a longstanding, consistent policy of any sort. *See INS v. Cordoza-Fonseca*, 480 U.S. 421, 446 n. 30 (1987) ["An agency interpretation of a relevant provision which conflicts with the agency's earlier interpretation is entitled to considerably less deference than a consistently held agency view"].

CONCLUSION

To paraphrase this Court, when the political branches of the Government act against the background of judicial interpretations of federal statutes already issued through the enactment of retroactive "clarifying" legislation, there is a risk that vital principles necessary to maintain separation of powers and the federal balance will be lost. Petitioners respectfully urge that the *writ of certiorari* issue to review the judgment of the Ninth Circuit in this matter.

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